Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Clint E. Hardin, DC

Respondent Name
Property & Casualty Insurance Company of Hartford

MFDR Tracking Number
M4-15-1597-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received a denial for this bill, stating 'THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING; THE BILLED SERVICE REQUIRES THE USE OF A MODIFIER CODE; WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT; AN ALLOWANCE HAS BEEN PAID FOR A DESIGNATED DOCTOR EXAMINATION AS OUTLINED IN 134.204(J) FOR ATTAINMENT OF MAXIMUM MEDICAL IMPROVEMENT. AN ADDITIONAL ALLOWANCE MAY BE PAYBLE IF A DETERMINATION OF THE IMAPRIMENT RATING CAUSDED BY THE COMPENSABLE INJURY WAS ALSO PERFORMED.

However, this is incorrect. The Impairment Rating was requested by the claimant's treating doctor … , the Impairment Rating results were documented in the report on page 9 of the 09/25/14 filed report, and the procedures were billed appropriately on the CMS-1500 using the correct CPT code and modifiers.

Please see the attached referral fax from the treating doctor, dated 9/19/14, requesting that Dr. Hardin perform this impairment rating.

We billed a total of $1,750.00 for these services. *We only received a $500.00 payment from your company.* **Please issue a prompt payment of $1,250.00 to settle this claim.**"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found that reimbursement was issued in accordance with Texas Fee Guidelines, Rule 134.204 (n) for CPT 99456 RE WP.

Modifier 'RE' represents return to work (RTW) and/or evaluation of medical care (EMC). Reimbursement for this service is $500."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2014	99456 RE WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 10 – The billed service requires the use of a modifier code
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(J) for attainment of Maximum Medical Improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
   - 247 – A payment or denial has already been recommended for this service.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j)(3) states, in relevant part, "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   28 Texas Administrative Code §134.204 (j)(4) states, in relevant part, "The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code…(C)(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.'"

   28 Texas Administrative Code §134.204 (k) states, in relevant part, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.'"

   Further, 28 Texas Administrative Code §134.204 (n) states, in relevant part, "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC)--This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed…(18) WP, Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP."

   Review of the submitted documentation finds that the requestor billed 99456 RE WP for the disputed services. This indicates that a RTW or EMC examination was performed. Documentation indicates the services performed were Maximum Medical Improvement and Impairment Rating. The Division finds that the requestor did not bill the disputed charges according to medical fee guidelines, using the correct modifiers. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	March 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.